Complete Summary

GUIDELINE TITLE

Wisconsin essential diabetes mellitus care guidelines.

BIBLIOGRAPHIC SOURCE(S)

Wisconsin Diabetes Advisory Group. Wisconsin essential diabetes mellitus care guidelines. Madison (WI): Wisconsin Diabetes Prevention and Control Program; 2004. Various p. [246 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Pre-diabetes
- Diabetes mellitus (type 1, type 2, gestational)
- Diabetes-related complications

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Cardiology
Dentistry
Dermatology
Emergency Medicine
Endocrinology
Family Practice
Gastroenterology
Geriatrics
Infectious Diseases
Internal Medicine
Nephrology
Neurology
Nursing
Nutrition
Obstetrics and Gynecology
Ophthalmology
Optometry
Pediatrics
Pharmacology
Physical Medicine and Rehabilitation
Podiatry
Preventive Medicine
Psychiatry
Psychology
Urology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dentists
Dietitians
Emergency Medical Technicians/Paramedics
Health Care Providers
Hospitals
Managed Care Organizations
Nurses
Pharmacists
Physical Therapists
Physician Assistants
Physicians
Podiatrists
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Social Workers
Students

GUIDELINE OBJECTIVE(S)

- To provide recommendations, which serves as a guide for the management of diabetes mellitus
- To provide a concise, general framework for the care and prevention of diabetes-related complications
- To improve care and enhance quality of life for people with diabetes

TARGET POPULATION

Patients with type 1 and type 2 diabetes mellitus, pre-diabetes, pre-gestational, or gestational diabetes

INTERVENTIONS AND PRACTICES CONSIDERED

General Care

1. Diabetes-focused visit including assessment of physical activity, weight, body mass index (BMI), growth, and review of management plan
2. Self-management education
3. Medical nutrition therapy
4. Glycemic control including:
    - A1c testing
    - Review of self-monitoring of blood glucose (SMBC)
    - Review of medication management monitoring, side effects, and hypoglycemic episodes
    - Glucose-lowering agents alone or in combination with one or more oral agents and/or insulin
5. Referral to specialists, as appropriate
6. Essential patient education

Cardiovascular Care

1. Lifestyle modification
2. Tobacco cessation
3. Lipid and blood pressure monitoring and therapy, including aspirin prophylaxis, unless contraindicated

Kidney Care

1. Obtain albumin/creatinine ratio, serum creatinine, and routine urinalysis, as appropriate
2. Angiotensin-converting enzyme (ACE) inhibitors or Angiotensin receptor blockers (ARB) and aggressive blood pressure therapy

Eye Care

1. Dilated eye exams

Foot Care

1. Routine and comprehensive foot exams
2. Risk categorization

Oral Care

1. Oral screening
2. Dental exam

Emotional/Sexual Health Care

1. Depression screening and recommendations
2. Assess sexual health concerns

Influenza and Pneumococcal Immunizations

1. Provide influenza and pneumococcal immunizations

Preconception and Pregnancy Care

1. Provide preconception counseling
2. Assess contraception/discuss family panning
3. Screen for gestational diabetes

Screening for Pre-diabetes and Diabetes

1. Fasting plasma glucose or oral glucose tolerance test

MAJOR OUTCOMES CONSIDERED

- Efficacy of management strategies at preventing, delaying, or reducing the risk of diabetes-related complications
- Glycemic control
- Quality of life
- Cost-effectiveness of care

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Expert Consensus (Committee)
Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus
Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Published cost analyses were reviewed and reported, not determined by the guideline developer.

Good glycemic control is cost-effective and improves quality of life. It is estimated that for every one percent decrease in A1c, there is a 14-20% decrease in hospitalizations, resulting in $4-5 billion savings in direct health care costs alone.

Screening for, and treatment of, diabetic kidney disease adds years to life and is proven to be cost-effective.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The authors of these Guidelines, the Wisconsin Diabetes Advisory Group, and many other individuals were involved in the review and revision of various drafts and the final document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

General Recommendations/Care

- Perform diabetes-focused visit

  Frequency

  - Type 1*: Every 3 months
  - Type 2*: Every 3-6 months

    * Consider more often if A1c ≥7.0% and/or complications exist

- Review management plan, assess problems and goals

  Frequency

  - Each focused visit; revise as needed
- Assess physical activity

  Frequency

  - Each focused visit
- Assess nutrition/weight/body mass index (BMI)/growth

  Frequency

  - Each focused visit

Self-Management Education

- Refer to diabetes educator, preferably a certified diabetes educator (CDE); curriculum to include the ten key areas of the national standards for diabetes self-management education

  Frequency

- At diagnosis, then every 6-12 months, or more as needed

Medical Nutrition Therapy

- Refer to registered dietician, preferably a certified diabetes educator; to include areas defined by the American Dietetic Association's Nutrition Practice Guidelines.

  Frequency

  - Type 1: At diagnosis; then, if age <18, every 3-6 months; if age ≥18, every 6-12 months.
  - Type 2: At diagnosis; then every 6-12 months or more as needed

Glycemic Control

- Check A1c (see Algorithm 1 in original guideline document)

  Goal: <7.0% or ≤1% above lab norms

  Frequency

  - Type 1: Every 3 months
  - Type 2: Every 3-6 months
- Review goals, medications, side effects, and frequency of hypoglycemia

  Frequency

  - Each focused visit
- Assess self-blood glucose monitoring schedule

  Frequency

  - Each focused visit, 2-4 times/day, or as recommended

Cardiovascular Care

- Check lipid profile

  Adult goals: Total Cholesterol <200 mg/dL
  Triglycerides <150 milligrams(mg)/dL
  High-density lipoprotein (HDL) ≥40 mg/dL (men)
  HDL ≥50 mg/dL (women)
  Non-HDL (Cholesterol) <130 mg/dL
  Low-density lipoprotein (LDL) <100 mg/dL (optimal goal)
  Low-density lipoprotein <70 mg/dL (for very high risk)

  Frequency

    - Children: If >2 years, after diagnosis and once glycemic control is established. Repeat annually if abnormal. Follow National Cholesterol Education Program (NCEP III) guidelines.
    - Adults: Annually. If abnormal, follow NCEP III guidelines.
- Blood pressure

  Adult goal: <130/80 mmHg

  Pediatric goal: below 90% of ideal for age

  Frequency

    - Each focused visit
- Assess smoking status

  Frequency

    - Each visit; if smoker, counsel to stop; refer to cessation
- Start aspirin prophylaxis (unless contraindicated)

  Frequency

    - Age >40 with diabetes; Age ≤40, individualize based on risk

Kidney Care

- Check albumin/creatinine ratio using a random urine sample, also called urine microalbumin/creatinine ratio (see Algorithm 2 in the original guideline document)

  Frequency

    - Type 1: Begin with puberty or after 5 years duration, then annually
    - Type 2: At diagnosis, then annually
- Check serum creatinine

  Frequency

    - At diagnosis, then annually
- Perform routine urinalysis

  Frequency

    - At diagnosis, then as indicated

Eye Care

- Perform dilated eye exam by an ophthalmologist or optometrist

  Frequency

- Type 1: If age ≥10, within 3-5 years of onset, then annually
- Type 2: At diagnosis, then annually; two exceptions exist (see Section 7 in the original guideline document)

Foot Care

- Inspect feet, with shoes and socks off

  Frequency

  - Each focused visit; stress need for daily self-exam
- Perform comprehensive lower extremity exam

  Frequency

  - Annually, with monofilament

Oral Care

- Perform oral health screening

  Frequency

  - At diagnosis, then each focused visit
- Advise dental exam by general dentist or periodontal specialist

  Frequency

  - At diagnosis, then every 6 months (if dentate) and every 12 months (if edentate)

Emotional/Sexual Health Care

- Assess emotional health; screen for depression

  Frequency

  - Each focused visit
- Assess sexual health concerns

  Frequency

  - Each focused visit

Immunizations

- Provide influenza vaccine

  Frequency

- Annually, if age ≥6 months
- Provide pneumococcal vaccine

  Frequency

  - Once; then per Advisory Committee on Immunization Practices

Preconception and Pregnancy Care

- Provide preconception counseling/assessment

  Frequency

  - 3-4 months prior to conception*
- Assess contraception/discuss family planning

  Frequency

  - At diagnosis and each focused visit*
- Screen for gestational diabetes

  Frequency

  - At 24-28 weeks gestation or sooner if high risk*

    * Consider referring to provider experienced in care of diabetic women during pregnancy.

Screening for Pre-diabetes and Diabetes

- Perform fasting plasma glucose test or oral glucose tolerance test (see Algorithm 6 in the original guideline document)

  Frequency

  - Test all people ≥age 45; if normal and person has no risk factors, retest in 3 years

Screening for Pre-diabetes and Diabetes

Test all people ≥45 years for pre-diabetes and diabetes. If screening results are normal and person has no risk factors, re-testing should occur at 3-year intervals. Screen at a younger age or more often if the person has one or more risk factors from the following list:

1. Body mass index ≥25 kilograms/m^2
2. Sedentary lifestyle
3. Prior history of pre-diabetes/glucose intolerance
4. Race/ethnicity (e.g., African-Americans, Hispanic-Americans, Native Americans, Asian-Americans, and Pacific Islanders)

5. Family history of diabetes in one or more first-degree relatives
6. History of hypertension (>140/90 mmHg)
7. History of vascular disease
8. History of dyslipidemia: HDL ≤35 mg/dL and/or a triglyceride level ≥250 mg/dL
9. Markers of insulin resistance: (e.g., acanthosis nigricans and/or waist circumference >40 inches in men and >35 inches in women)
10. History of polycystic ovary syndrome (PCOS)
11. History of gestational diabetes mellitus (GDM) in women or delivery of a baby weighing more than nine pounds at birth

Diagnosis of Pre-diabetes and Diabetes (2004 Criteria)

Fasting Plasma Glucose (FPG)

How Performed: Blood glucose is measured after at least an 8 hour fast

Normal: <100 mg/dL

Pre-diabetes (impaired fasting glucose [IFG]): 100-125 mg/dL

Diabetes Mellitus: ≥126 mg/dL*

Oral Glucose Tolerance Test (OGTT)

How Performed: 75-gram glucose load (drink) is ingested after at least an 8-hour fast; blood glucose is measured at 2 hours

Normal: <140 mg/dL

Pre-diabetes (impaired glucose tolerance [IGT]): 140-199 mg/dL

Diabetes Mellitus: ≥200 mg/dL

Random/Casual Plasma Glucose (with symptoms)

How Performed: Blood glucose is measured at any time regardless of eating

Diabetes Mellitus: ≥200 mg/dL (with symptoms)* #

*Test must be confirmed by repeating on a different day

It is not appropriate to have a person eat a meal and then draw a random glucose two hours after.

CLINICAL ALGORITHM(S)

Clinical algorithms are provided in the original guideline document for:

- Type 2 Diabetes: Glycemic Control

- Screening and Initial Recommendations for Diabetic Kidney Disease (Microalbuminuria and Macroalbuminuria)
- Diabetic Foot Disorders ULCER: A Clinical Practice Pathway
- Diabetic Foot Disorders INFECTION: A Clinical Practice Pathway
- Diabetic Foot Disorders CHARCOT FOOT: A Clinical Practice Pathway
- Screening for Pre-diabetes and Diabetes

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on results of clinical trials, accepted science, and expert opinions.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Potential Benefits

- Prevention, early detection, and aggressive treatment can have a significant impact on the quality of life for people with diabetes.
- The management goal for diabetes is to achieve optimal glycemic control to prevent acute and chronic complications.

Specific Potential Benefits

Self-Management Education

The primary goal of diabetes self-management education (DSME) is to provide knowledge and skill training, facilitate problem solving, help people identify barriers to change, and nurture the development of coping skills with the goal of achieving effective self-management and behavior change.

Medical Nutrition Therapy

Early intervention and follow-up of medical nutrition therapy (MNT) are essential to achieve and maintain glycemic control and reduce the risk of cardiovascular disease and other complications. As the sole therapy, or in conjunction with other therapies, MNT can help prevent and/or delay the onset or progression of costly diabetes-related complications and hospitalizations.

Glycemic Control

Good glycemic control is cost-effective and improves quality of life. It is estimated that for every one percent decrease in A1c, there is a 14-20% decrease in hospitalizations, resulting in $4-5 billion savings in direct health care costs alone

Cardiovascular Care

Aggressive assessment and treatment of cardiovascular disease may prevent or decrease the development of cardiovascular complications.

Kidney Care

Early detection and intervention of diabetic kidney disease, along with improved glycemic and blood pressure control, can help reduce the risk of the development and progression of nephropathy. Screening for, and treatment of, diabetic kidney disease adds years to life and is proven to be cost-effective.

Eye Care

Studies have shown that early detection and proper treatment of diabetic eye disease can reduce the risk of diabetic retinopathy and blindness by 50-60%. In addition, proper glycemic control can reduce the risk of progression of retinopathy by 34-76%. For each two percent decrease in A1c, there is a 50-75% reduction in complications. Not only do diabetic retinopathy screening and treatment programs result in increased years of sight, but they are clearly also cost-saving interventions.

Foot Care

Simple prevention strategies may reduce the rate of lower extremity complications in people with diabetes.

Oral Care

The negative outcomes of periodontitis can be avoided through appropriate screening and timely referral and treatment.

Emotional/Sexual Health Care

Early recognition of depression symptoms, prompt treatment, and referral may lead to improved diabetes self-care and quality of life.

Influenza and Pneumococcal Immunizations

Immunizations can prevent serious illness, complications, hospitalizations, and death associated with influenza and pneumococcal disease.

Preconception and Pregnancy Care

Preconception counseling, intensive management to optimize glycemic control before pregnancy and during pregnancy, and utilizing a team of providers experienced in caring for women with diabetes may help these at risk women achieve health outcomes similar to those of women without diabetes.

Screening for Pre-diabetes and Diabetes

Evidence from studies have shown supportive education for medical nutritional therapy and self-management after the diagnosis of pre-diabetes are effective in slowing and even preventing the progression to Type 2 diabetes.

POTENTIAL HARMS

For information on side effects of diabetes medications, see "Diabetes medications update - 2004" at the end of Section 4 in the original guideline document.

CONTRAINDICATIONS

CONTRAINDICATIONS

For information on contraindications to common diabetes medications, see "Diabetes medications update - 2004" at the end of Section 4 in the original guideline document.

QUALIFYING STATEMENTS

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- The Guidelines are population-based and therefore intended to be appropriate for most people with diabetes, but not intended to define the optimal level of care that an individual person may need. Clinical judgment may indicate the need for adjustments appropriate to the needs of each particular person (e.g., age, medical condition, or individual glycemic control goal).
- The recommendations in these Essential Diabetes Mellitus Care Guidelines are intended to serve as a guide for clinicians and others involved in the implementation of care and preventive services for people with diabetes. They are not intended to replace or preclude clinical judgement. Abnormal physical or lab findings should result in follow-up/intervention.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Phase 1

Wisconsin healthcare professionals were invited to attend one of the 11 programs offered around the state of Wisconsin. These free workshops, that featured a healthy breakfast and continuing education credits, educated the professionals about the newly updated Wisconsin Essential Diabetes Mellitus Care Guidelines.

Community members were invited to one of the 11 free evening programs held around the state, featuring healthy snacks, to learn about the newly updated Wisconsin Essential Diabetes Mellitus Care Guidelines.

Phase 2

In response to multiple requests to provide Phase 1 in many more locations across the state, the Wisconsin Essential Diabetes Mellitus Care Guidelines Training Project CDs were designed by health systems to implement successful health professional and/or community training on the Wisconsin Essential Diabetes Mellitus Care Guidelines.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Chart Documentation/Checklists/Forms
Clinical Algorithm
Foreign Language Translations
Patient Resources
Quality Measures
Quick Reference Guides/Physician Guides
Resources
Slide Presentation
Wall Poster

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Wisconsin Diabetes Advisory Group. Wisconsin essential diabetes mellitus care guidelines. Madison (WI): Wisconsin Diabetes Prevention and Control Program; 2004. Various p. [246 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Dec

GUIDELINE DEVELOPER(S)

Wisconsin Diabetes Prevention and Control Program - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

Centers for Disease Control and Prevention (CDC), Division of Diabetes Translation

GUIDELINE COMMITTEE

Guidelines Work Groups and Diabetes Advisory Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Wisconsin Diabetes Prevention and Control Program Web site.

Print copies: Available from the Wisconsin Diabetes Prevention and Control Program, Bureau of Community Health Promotion, PO Box 2659, Madison, WI 53701-2659.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Wisconsin diabetes strategic plan 2004-2009. Madison (WI): Wisconsin Diabetes Advisory Group. Department of Health and Family Services, Division of Public Health, Diabetes Prevention and Control Program. 2004 Oct.
- Making a difference: essential diabetes care in Wisconsin 2005. Webcast. 2005.

- Diabetes self-management information and record booklet and wallet card (English and Spanish).
- Diabetes Advisory Group. Diabetes guidelines professional presentation 2005. Madison (WI): Wisconsin Diabetes Prevention and Control Program. 2005.

Electronic copies: Available from the Wisconsin Diabetes Prevention and Control Program Web site.

Additionally, the Wisconsin Diabetes Advisory Group has made available a variety of implementation tools included in the original guideline document:

- Body mass index (BMI) tables for adults
- Growth charts for children
- Diabetes self-management education records
- Diabetes patient flow sheet/chart audit tools
- Diabetes sick day plan
- Diabetes eye exam consultation form
- Annual comprehensive diabetes foot exam form
- Office poster (available in English, Spanish, and Hmong)
- High-risk foot stickers for patient record
- Diabetes dental referral form
- Patient Health Questionnaire (PHQ-9)
- Diabetes population-based indicators
- Personal diabetes care record cards (available in English, Spanish, and Hmong)

Electronic copies: Available in the original guideline document and from the Resources section of the Wisconsin Diabetes Prevention and Control Program Web site.

PATIENT RESOURCES

The following is available:

- Diabetes self-management information and record booklet. Madison (WI): Wisconsin Diabetes Advisory Group. Department of Health and Family Services, Division of Public Health, Diabetes Prevention and Control Program.

Electronic copies: Available from the Wisconsin Diabetes Prevention and Control Program Web site.

Print copies: Available from the Wisconsin Diabetes Prevention and Control Program, Bureau of Community Health Promotion, PO Box 2659, Madison, WI 53701-2659; phone: (608) 261-6855.

authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

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